REQUEST FOR PROPOSAL

for

Pharmacy Benefit Management Services for Fee-For-Service Programs RFP #1563 DHCF-LS

Wisconsin Department of Health and Family Services
June 26, 2006

Table of Contents of Major Sections

Section 1 RFP Introduction

Section 2 Contract Monitoring

Section 3 Format for Submitting Technical Proposal

Section 4 Format for Submitting Cost Proposal

Section 5 Contract Business Requirements

List of Appendices

SECTION 1

RFP INTRODUCTION

The purpose of this Request for Proposal (RFP) is to solicit bids for alternative Pharmacy Benefit Management (PBM) services for fee-for-service (FFS) eligibles of Wisconsin Medicaid, BadgerCare, SeniorCare and all related programs that require pharmacy claims processing (such as the Wisconsin Chronic Disease Program). These programs are administered by the Department of Health and Family Services (hereinafter referred to as the **State**).

The State retains the right to accept or reject any or all Proposals if it is deemed to be in the best interest of the State.

This Request for Proposals (RFP) is being issued by the State of Wisconsin, Department of Health and Family Services (DHFS). DHFS is the sole point of contact for all Respondents from the date of release of the RFP until the contract is fully executed and signed. The RFP is officially released via the State's VendorNet system.

The purpose of this section is to describe the contract type and term, tentative schedule, procurement rules and processes, and detailed proposal submission requirements for responding to this RFP.

1.0 Overview

This RFP solicits bids for the delivery of PBM services and defines three "Procurement Packages" for which potential vendors may submit bids. Respondents may submit bids for any or all of these packages (see section 1.01 for Procurement Package details). Respondents bidding on more than one package must submit technical and cost proposals for each. Responses in one package cannot be cross-referenced in the other as each package will be read and scored independently. During the evaluation process, the Department will select the package it determines to provide the greatest cost/benefit value to the state. The following PBM "value chain" defines the components of the procurement packages:

1.0.1 Wisconsin Medicaid PBM Value Chain

Prospective DUR

- Clinical rules, algorithms and profiling
- Point-of-sale match with Rx claims history
- Point-of-sale match with medical claims history

Preferred Drug List (PDL) and Supplemental Rebate Solicitation/Negotiation

- Meta analysis of clinical evidence
- Provide staff to assist DHFS Medicaid Prior Authorization (PA) Advisory Committee
- Solicit and negotiate supplemental rebate agreements, potentially including multi-state or multi-payer pooling
- Provider Communication and Education re Preferred Drug List
- Provider communications
- Manage web content of PDL and all related documents and forms.
- Distribution of PDL, including electronic methods like Epocrates.

Prior Authorization (PA)

- Point of Sale PA resolution
- Web Based PA
- Application of Step Therapy rules.

Point of Sale Claims Adjudication and Payment

- Eligibility verification via Medicaid Management Information System (MMIS) interface. Please see section 1.02 for discussion of current role of MMIS in management of pharmacy benefit.
- Capacity for interface with Wisconsin Forward eligibility card
- Benefit and copay determination
- Pricing
- Coordination of Benefits (COB) with Part D and other insurance plans, including interface with CMS' COB reporting (TrOOP).
- Claims payment
- Data acquisition, preservation, warehousing and reporting
- Exception processing
- Pharmaceutical Care claims processing.

Rebate Billing and Collections

- Federal and supplemental rebate invoicing
- Federal and supplemental rebate dispute resolution
- Federal and supplemental rebate collections and reporting

Retrospective DUR

- Data warehouse (Rx data)
- Analytic tools and reports
- Clinical rules and algorithms and profiling

- Professional judgment and review
- Provide staff to work with DUR Board
- Physician and recipient education and counter-detailing

Cost Containment Consultation and Implementation

- Recipient lock-in
- Dose consolidation, pill splitting
- Policy Changes
- Other cost containment strategies
- Analytical tools and reports
- Expenditure projections

The three procurement packages contain the following components (and all related subcomponents) of this value chain:

Procurement Package 1

Prospective DUR Rules, Algorithms, Profiling and Point-of-Sale Implementation
Preferred Drug List and Supplemental Rebate Solicitation/Negotiation
Prior Authorization
Claims Adjudication and Payment
Rebate Billing and Collection
Retrospective DUR
Cost Containment Consultation and Implementation
Interface with MMIS as necessary

Procurement Package 2

Prospective DUR Rules, Algorithms and Profiling
Preferred Drug List and Supplemental Rebate Solicitation/Negotiation
Prior Authorization
Retrospective DUR
Cost Containment Consultation and Implementation
Interface with MMIS as necessary

Procurement Package 3

Prospective DUR Rules, Algorithms and Profiling
Prior Authorization
Retrospective DUR
Cost Containment Consultation and Implementation
Interface with MMIS as necessary

Again, Respondents may submit bids for any or all of these procurement packages. Separate technical and cost proposals are required for each package.

1.0.2 Current PBM Services and Procurement Rationale

The State contracts with a Fiscal Agent to operate, maintain and enhance the federally required Medicaid Management Information System (MMIS) and to provide a wide scope of administrative, technical, clinical and analytical services to support the administration of the Department's health care programs. In 2004, the Department administered a competitive procurement for fiscal agent services, including pharmacy claims payment and management services. EDS was awarded the contract that resulted from this procurement. EDS currently subcontracts with vendors such as APS (to provide services such as DUR, recipient lock-in and clinical implementation of savings proposals) and Provider Synergies (to provide PDL administration and supplemental rebate negotiation). The scope and requirements of the fiscal agent contract can be found at dhfs.wisconsin.gov/rfp/.

The MMIS procurement required the design, development and implementation (DDI) of a new MMIS over a period of 24 months. That DDI process began in January 2005, and implementation of the new MMIS is scheduled to occur early in 2007. The contract has a 5 year base operational term with 5 optional one year extensions. The scope of the fiscal agent contract includes requirements for the full scope of PBM systems and activities.

In 2005, the Department began to explore the idea of carving PBM services out of the MMIS contract. The Department considered whether greater cost savings could be achieved in the pharmacy program by contracting for specialized PBM services under a contract scope that focused exclusively on pharmacy benefit management.

These considerations were prompted by the rapidly changing context within which pharmacy benefits are being managed in both the public and private sector nationwide. In recent years it has become clear that there are many complex mechanisms available through which pharmacy benefit administrators can actively intervene to successfully extract substantial savings while maintaining high-quality pharmacy benefits. In light of this, a trend toward specialized PBM vendors has developed.

In June 2005, the State of Wisconsin issued Request for Information (RFI) number 0503-ES to solicit additional information on the availability of specialized PBM services. The purpose of the RFI was to determine if new, innovative tools that had more recently come to market had the potential to further reduce the cost of providing pharmacy benefits to Medicaid, BadgerCare and SeniorCare fee-for-service recipients.

Based on information received in this RFI, the State determined that the evolution of tools available in the specialized PBM vendor market had advanced to the point where a potential carve out of PBM activities from the larger MMIS contract was worth pursuing.

The State has structured this RFP to include three procurement packages to better facilitate a decision on whether the greatest cost effectiveness can be realized by carving out all components of PBM services, or, alternatively, by substituting only select management and consulting services.

The State still maintains the right to determine that, as a result of responses received to this RFP, the status-quo of maintaining PBM services entirely within the current MMIS contract is in its best interest. If this is so, the State reserves the right to not award a contract as a result of this RFP.

Should the State decide to award a contract as a result of this RFP, the functional components of the chosen package will be removed from the current MMIS contract. Those components will thus be alternately procured through the contract that results from this RFP. Because of this, all applicants must assume, in developing their cost proposals, that funding for PBM services in the package that is ultimately selected for procurement will be available only through the award of this contract. Therefore, the current MMIS vendor will continue to provide all PBM services to the State if 1) they are awarded a contract as a result of this RFP, or 2) the State concludes this process by deciding not to carve any PBM services out of the MMIS contract.

The scope of services within this RFP reflects the State's goal to provide PBM services that meet the State's quality, performance and budget requirements. Section 2 of the RFP defines the terms of contract oversight as envisioned by the State. Section 3 defines the technical requirements for the PBM services to be provided by the Contractor and itemizes supplemental questions about Respondents' technical proposals. Section 4 contains costing instructions for Respondents to use in their Proposals. The appendices provide additional information that further clarify and define the scope of services being required.

1.1 Definitions and Contract Term

The term "Contractor" is used throughout the document to define the PBM Contractor eventually selected as a result of this RFP.

The term "Respondents" is used throughout the document to define any and all entities submitting Proposals under this RFP. Any entity meeting this definition

shall be, for purposes of this procurement, referred to as a "Respondent." The term "Potential Vendor" is sometimes used interchangeably with "Respondent."

The contract period for services acquired through this RFP shall be for five (5) years initially with the State solely reserving the option to renew the contract under the same terms and conditions for five (5) additional one (1) year periods.

1.2 RFP Point of Contact

Rich Albertoni
Wisconsin Department of Health and Family Services
Division of Health Care Financing
One West Wilson Street, Room 350
Madison, WI 53702
(608) 266-9438 (phone)
(608) 266-1096 (FAX)

From the date of release of this RFP until a selection determination is made and announced regarding the award of a contract as a result of this RFP, all contacts regarding this RFP, with personnel in public office (Federal, State, or Local), or individuals or organizations contracted to the State of Wisconsin or associated with this RFP, are restricted.

No prospective Respondent (including any employee, agent, or subcontractor thereof) shall approach (in any manner whatsoever) personnel employed by or contracted to the State of Wisconsin or any other public agency participating in the Wisconsin Medicaid Program regarding this RFP or this project without the prior express written permission of DHFS.

Violation of these conditions may, at the sole discretion of DHFS, be considered sufficient cause by DHFS to reject a proposal, irrespective of any other consideration.

1.3 Procurement Schedule

The proposed procurement schedule is detailed in the following chart. Revisions to this schedule shall be made as an amendment to this RFP.

Procurement Activity	Proposed Date
RFP Released on VendorNet Supplemental Q106 Data Extract Available to Vendors who sign data sharing agreement	June 26, 2006
Deadline for receipt of Written Questions	July 7, 2006; 4:00 PM CDT

Procurement Activity	Proposed Date
Estimated Date for Release of Written Answers to Respondents' Questions.	July 21, 2006
Proposals Due (Technical and Cost)	August 4, 2006; 4:00 p.m. CDT
Oral Presentations	Week of August 14,, 2006
Finalist Interviews	August 21, 2006
Notice of Intent to Award Contract	September 1, 2006
Contract Negotiation/ PBM Implementation	Sept 1 – Dec 31, 2006

1.3.1 Notes to Procurement Schedule

Prospective Respondents may submit questions concerning this RFP to the RFP Contact designated in Section 2.0.

- The State will answer questions in writing that are received by the due date and time. All Respondents submitting questions, or those requesting answers to written questions, shall be supplied with the answers to all questions that are selected for response.
- Oral presentations will afford Respondents an opportunity to provide clarification on questions and issues the State may have relative to Proposals. All Respondents shall participate in the oral presentation at their own expense. Failure to participate in the oral presentation may disqualify the Respondent from further consideration in this RFP process.
- Proposals received after the cutoff date and time will not be accepted. An original and seven (7) copies of the proposal shall be submitted. **Faxed versions of the proposal shall not be accepted at any time during the process.**

Respondents may be requested to provide a Best and Final Offer at a date and time subsequent to the oral presentations.

It is the intent of the State to have a fully-negotiated and signed contract as soon as possible after negotiations begin. If contract negotiations with the Selected Contractor are unsuccessful, the State shall end negotiations with said Contractor and may begin negotiations with the Respondent having achieved the second highest score during the evaluation of the Proposals. Selection of a Respondent for contract negotiations does not, in and of itself, ensure a contract with the State for PBM services. The ultimate entry into a contract with the State for such services is entirely contingent upon the successful negotiations of all contract terms and conditions.

If it becomes necessary to revise any part of this RFP, an amendment shall be placed on VendorNet. The State reserves the right to amend the RFP at any time prior to the proposal due date by issuing written amendment(s). All written amendments to the RFP shall become part of the Contract.

The Department reserves the right, at its sole discretion, to reject any or all proposals, pursuant to the Wisconsin Administrative Code, Chapter Adm 10.08(1) (f). The Department reserves the right, at its sole discretion, to cancel this procurement at any time.

1.4 Requirements for Responding to the RFP

If Respondents choose to apply for more than one procurement package, a separate technical and cost proposal must be submitted for each.

The specific instructions for completing the technical proposal are documented in Section 3. Specific instructions for completing the cost proposal are documented in Section 4.

The technical and cost components of each proposal must be submitted in completely separate envelopes clearly labeled on the outside of the envelope.

All Proposals must address all requirements in this RFP in order to be considered for Contract award. To receive consideration, the proposal must be received no later than 4:00 PM CDT on August 4, 2006. A signed original and seven (7) copies of the technical proposal (separate from the cost proposal) are required. A signed original and seven (7) copies of the cost proposal (separate from the technical proposal) are likewise required.

Technical and cost proposals must be submitted to:

Rich Albertoni
Division of Health Care Financing
Department of Health and Family Services
One West Wilson Street, Room 350
Madison, WI 53702
alberrs@dhfs.state.wi.us

The technical proposal and envelope must be clearly marked as:

PBM RFP Technical Proposal
Name and Address of Respondent
RFP Number 1563 DHCF-LS

The hard copy of each proposal must be accompanied by an electronic copy stored on a CD and labeled as above.

The cost proposal(s) and the envelope must be clearly marked as:

PBM RFP Cost Proposal
Name and Address of Respondent
RFP Number 1563 DHCF-LS

The hard copy of each Proposal must be accompanied by an electronic copy stored on a CD and labeled as above.

Respondents must also submit one copy of technical proposal and one copy of the cost proposal on separate CDs, labeled appropriately, with the appropriate original hardcopy proposal.

Again, you may be submitting more than one technical and cost proposals depending on which procurement packages on which you choose to bid.

No other distribution of proposals will be made by the Respondent. Proposals must be signed by an official authorized to bind the Contractor to Contract and Transmittal Letter provisions. The technical and cost proposals submitted in response to this RFP will remain valid for at least two hundred-seventy (270) days. Moreover, the contents of the selected Contractor's proposal will become Contractual obligations if a Contract is entered into. Submission of a proposal will constitute Respondent's understanding, acceptance, and consent to adhere without any reservation or limitation whatsoever to the requirements, terms, and conditions of this RFP, including any RFP addenda. This consent to adhere to requirements will also apply to the Respondent's use of all schedules contained in all Appendices and Attachments. Failure in whole or in part of the Respondent to respond to a specific mandatory requirement may be the basis for elimination from consideration during the Department's review of Proposals. Failure by a Respondent to meet, in whole or in part, requirements specified in the RFP may result in rejection of the Proposal. Receipt of proposals by the Department confers no rights upon the Respondent. Receipt of proposals will not, in any manner whatsoever, obligate DHFS, the State of Wisconsin, the federal CMS (Centers for Medicare and Medicaid Services), or any employees thereof. This RFP may or may not result in the awarding of a Contract. DHFS reserves the right to cancel this procurement at any time.

Proposals must be clear, concise, and direct. The proposals should fully describe the approach and solution, but not include marketing or other materials that are not requested in the RFP or add little or no value to DHFS' understanding of the Proposal. Brochures or other presentations, beyond that sufficient to present a complete and effective proposal, are not desired. Audio and/or videotapes are not allowed. Elaborate artwork, expensive paper, expensive binders, and expensive visual and other presentation aids are not necessary.

Proposals submitted in whole or in part by fax or e-mail will be rejected. Late proposals will be rejected and will be returned unopened. **There will be no exceptions.**

1.5 Open Records Law and Confidentiality

The Wisconsin Open Records Law requires public disclosure of all sealed proposals and related documents upon issue of intent to award. In addition, after issuance of the Notice of Intent to Award a Contract, all opened and qualified proposals are considered open records. Inspection is subject to the statutes and rules of the State of Wisconsin.

Respondents shall complete Form DOA-3027, Confidentiality and Trade Secrets Declaration Form, for items or materials that can be kept confidential under the Wisconsin Open Records Law. This form shall be completed and filed with each Respondent's Technical Proposal.

DHFS will make an independent determination as to which items or materials may be considered closed records or nonpublic records. If the proposal includes material that is considered by the Respondent to be proprietary and confidential under Wisconsin law, the Respondent shall clearly designate the material as such.

The Respondent shall identify each page or section of the proposal that it believes is proprietary or confidential, with sufficient grounds to justify each exemption from release, including the prospective harm to the competitive position of the Respondent if the identified material were to be released.

In all cases, cost proposals will be considered open records upon the Department's issuance of the notice of intent to award. Therefore, Respondents may not declare their cost proposals (or any portion thereof) as confidential or proprietary.

The contents of the Technical Proposal and Cost Proposal, as accepted by the State, will become part of any contract awarded as a result of this RFP.

1.6 Proposal Amendments and Rules for Withdrawal

Prior to the proposal due date, a submitted proposal may be withdrawn by submitting a written request for its withdrawal, signed by the Respondent's authorized agent, to the State's RFP Contact, providing an explanation for the action. Return postage cost will be paid by the Respondent. Respondents are allowed to make amendments or corrections to their proposals at any time prior to the proposal due date, without penalty. To amend or correct a proposal, Respondents shall request that their proposal be returned. Return postage cost will be paid by the Respondent. The proposal shall be resubmitted to DHFS prior to the original proposal due date in order to be considered for evaluation.

1.7 Proposal Evaluation Information

The purpose of this section is to provide a description of the evaluation process and the criteria that the State shall employ in the selection of a Contractor. All Proposals received by the closing deadline shall be evaluated according to the criteria herein.

A complete proposal consists of a technical proposal and a cost proposal. Scoring of the technical proposal will account for 75% of the total evaluation score. Scoring of the cost proposal will account for 25% of the total evaluation.

The technical proposal consists of four main sections as follows:

1) A Statement of the Contractor's Qualifications and Experience as outlined in Section 3.1.

2) Responses to Technical Questions provided in Section 3.2.

3) Submission of a "Cost Savings Opportunity Report" based on a Medicaid/SeniorCare January-March 2006 claims extract to be provided to Respondents who sign a data sharing agreement with the State of Wisconsin. The format for this report must follow specifications outlined in Section 3.3.

4) An Implementation and Integration Plan as specified in Section 3.4. Each of these four components will be assigned a relative value for evaluation purposes to be determined by the State. The complete evaluation scoring system is subject to public review after the notice of intent to award contract.

After the Evaluation Committee has scored the Technical and Cost Proposals, final scores from each Technical and Cost Proposal shall be tallied, combined and ranked.

The Evaluation Committee will prepare an evaluation report summarizing the evaluation process it followed, the findings from evaluation scoring, a recommendation for selection, reasons for its recommendation and any other concerns regarding the selection decision.

These findings and recommendation will go to the Selection Committee for the final selection decision or a determination to request Best and Final Offers. When the Best and Final Offer is received from the requested proposer(s) scores will be recalculated based on that submittal. The Selection Committee will make the final selection decision.

1.8 Independent Price Determination

By submission of a proposal, the Respondent certifies, and in the case of a joint proposal, each party thereto certifies as to its own organization and in connection with this procurement that:

- the prices proposed have been arrived at independently, without consultation, communication, or agreement, for the purpose of restricting competition, as to any matter relating to such prices with any other Respondent or with any other competitor;
- unless otherwise required by law, the prices quoted have not been knowingly disclosed by the Respondent on a prior basis, directly or indirectly, to any other Respondent or to any other competitor; and
- no attempt has been made, or will be made, by the Respondent to induce any other person or firm to submit or not to submit a proposal for the purpose of restricting competition.

By signing the proposal, each person(s) certifies that:

- the person is the individual in the Respondent's organization responsible within that organization for the decision as to the prices being offered and that they have not participated in any action contrary to the above; or
- the person is not the individual in the Respondent's organization responsible within the organization for the decision as to the prices being offered but that the person(s) has been authorized, in writing, to act as agent for the persons responsible for such decisions in certifying that such persons have not, and will not, participate in any action contrary to the above, and as their agent does hereby certify, has not and will not participate in any action contrary to the above.

1.9 Transmittal Letter

A Transmittal Letter must be submitted with each technical proposal. The Transmittal Letter shall be written on the Respondent's official business letterhead. The letter transmits the proposal and identifies all materials and enclosures being forwarded collectively in response to this RFP. An individual authorized to contractually and legally commit the Respondent to the scope of work proposed must sign the original Transmittal Letter. The Transmittal Letter must include the following items in the order given:

1. A list of all materials and enclosures being forwarded in response to the RFP.
2. A reference to all RFP amendments posted to VendorNet and reviewed by the Respondent (by amendment issue date), to warrant that the Respondent is aware of all such amendments. If no amendments have been posted prior to

proposal submission, the Respondent shall make a statement to that effect in the transmittal letter.

3. A statement that the Respondent believes the proposed solution meets all the general, technical, and functional capability requirements set forth in the RFP.
4. A statement that pricing was arrived at without any collusion or conflict of interest.
5. A statement, if applicable, that the prime contractor is a Minority Business Enterprise (MBE) in accordance with Wis.Stats.16.75(3m).
6. A statement that no cost or pricing information has been included in the Technical Proposal.
7. A statement that the Respondent will develop and operate a PBM which meets all performance requirements set forth in this RFP, or clearly specifies any deviations.

The original signed copy of the Transmittal Letter shall be submitted in a separate, sealed envelope inside the package containing the Technical Proposals. All other copies of the Transmittal Letter will be included with the copies of the Technical Proposal.

1.10 Award Notice and Award Authority

Upon completion of the evaluation of the technical and cost proposals DHFS will issue a Notice of Intent to Award a Contract based on the final recommendation made by the evaluation committee. The notification will be sent by the Department to all Respondents. Such a Notice of Intent to Award a Contract under this RFP shall not constitute an agreement nor shall it authorize the selected Respondent to initiate the project or incur costs under the RFP or contract.

Notification of Intent to Award a Contract, as well as subsequent execution of the Contract, is contingent upon approval of the selected contractor and the approval of the final Contract by the State and by the Federal Centers for Medicare and Medicaid Services. Final authority to award the Contract rests with the Secretary of the Wisconsin Department of Health and Family Services or their designee.

After notification of the intent to award is made, and under the supervision of agency staff, copies of proposals will be available for public inspection from 8:00 a.m. to 4:30 p.m. at One West Wilson Street, Madison, Wisconsin 53702.

1.11 Appeals Process

Notices of Intent to Protest and actual protests shall be made in writing. Protestors should make their protests as specific as possible and should identify statutes and Wisconsin Administrative Code provisions that are alleged to have been violated.

The written notice of intent to protest the Notice of Intent to Award a Contract shall be filed, in writing, with:

Helene Nelson, Secretary
Wisconsin Department of Health and Family Services
One West Wilson Street, Room 650
P.O. Box 7850
Madison, WI 53707-7850

Notice of Intent to Protest shall be received in her office no later than five (5) working days after the Notice of Intent to Award is issued. The written protest shall be received in her office no later than ten (10) working days after the Notice of Intent to Award is issued. (The date the notice of intent is issued is the date appearing at the top of the notice).

The protest decision will be made by the Secretary of the Department of Health and Family Services. The decision of the Secretary may be appealed to the Secretary of the Department of Administration within five (5) working days of issuance, with a copy of such appeal filed with the procuring agency, and provided the appeal alleges a violation of a Wisconsin statute or a provision of the Wisconsin Administrative Code.

1.12 Disposition of Proposals

Proposals submitted in response to this RFP shall become the exclusive property of the DHFS and may be retained, returned, used, reproduced, distributed, and/or destroyed by the DHFS, at its sole discretion. For purposes of public record keeping, the State shall retain at least one (1) copy of each proposal.

The State of Wisconsin shall have the right to use all ideas, or adaptations of those ideas, contained in any proposal received in response to this RFP.

1.13 Cost Liability

The State of Wisconsin assumes no responsibility or liability for any costs incurred by Respondents, including, but not limited to, costs associated with (a) developing and submitting proposals, (b) participating in the Oral Presentation, (c) preparing written questions, (d) responding to the State's questions and requests for clarification, (e) participating in oral presentations/demonstrations, or (g) protesting or appealing this procurement or the intent to award the Contract to a competitor.

1.14 Current and Historical Program Information

The following information is provided to Respondents for use in preparing their Proposals under this RFP. Information provided in the balance of Section 1 includes an overview of the current Wisconsin Medicaid Program, how it is currently administered in an overall sense, and, finally, a synopsis of its current

operating premises with regard to the management of pharmacy benefits within the current structure.

1.15 Division of Health Care Financing (DHCF) Programs

Wisconsin Medicaid is a federal/state partnership that provides a comprehensive package of medical services to low-income children and families, elderly and disabled State residents. The State Department of Health and Family Services, Division of Health Care Financing administers the program. As of February 2006, a total of 838,357 eligible individuals were enrolled, receiving services through the Fee-for-Service (FFS) program, managed care and institutional settings.

Medicaid Fee-for-Service Enrollment and Pharmacy Costs

	2006Q1	2006Q1	2006Q1
Program	**Recipients**	**Prescrips.**	**Paid**
Medicaid	190,516	1,143,424	$68,182,357
SeniorCare	87,657	1,128,287	$37,059,710
Total	**278,173**	**2.271,711**	**$105,242,067**

* Dispensing fees plus ingredient cost at MAC or AWP minus 13%, not including recipient cost sharing. Including recipient cost sharing, SeniorCare paid rises to $51,770,216.
These amounts are post-Medicaid Part D.

Effective January 1, 2006, Medicaid drug coverage for dual eligibles ended, as the Medicare Part D benefit was implemented. This reduced Medicaid FFS drug spending by approximately 64% (reflected above) and reduced the recipient count by approximately 35%. SeniorCare drug benefits have continued unchanged.

Authorization to operate the SeniorCare program currently expires on June 30, 2007. Federal approval is required to continue the program after June 30, 2007. In the event the program is not reauthorized, a reduction in the number of fee-for-service pharmacy claims may result.

The State has adopted a variety of strategies to control escalating drug expenditures that are unique to state programs as well as techniques commonly used by the private sector. Innovative, cost-effective, expenditure reduction proposals identified in this RFP may be considered either as potential complete replacements of existing program administration and policies or as components that complement existing programs.

The Division of Health Care Financing (DHCF) is responsible for implementing the pharmacy program for Medicaid, including establishing policies, setting operational guidelines and supervising the provision of Medicaid pharmaceutical providers. DHFS/DHCF has a current contract with Electronic Data Systems (EDS) to provide fiscal agent services for Medicaid. EDS designs, operates and maintains the Medicaid claims processing system to meet Wisconsin and federal Medicaid Management Information Systems (MMIS) requirements.

Wisconsin Medicaid is composed of the following programs:

- Standard Medicaid (649,225 enrolled as of 2/06) – Very low-income children, parents and pregnant women (AFDC and Healthy Start) and elderly and disabled (SSI).
- BadgerCare (91,855 enrolled as of 2/06) – Children and parents up to 185 percent of the federal poverty level (FPL).
- SeniorCare (83,775 enrolled as of 2/06) – Seniors up to 200 percent FPL (pharmacy benefit only).
- Non-Medicaid SeniorCare (13,682 enrolled as of 2/06) – Seniors 200 to 240 percent FPL who are provided a pharmacy benefit only that is funded entirely by the State with no federal Medicaid match.
- Wisconsin Medicaid also funds a number of sub-programs designed to promote the health and independence of the elderly, disabled and others, including Family Care, Home and Community-Based Waivers, Well Woman, Katie Beckett and the Medicaid Purchase Plan.

1.16 Administering Medicaid Programs at the State Level

The state contracts with a Fiscal Agent to maintain and enhance the federally required Medicaid Management Information System(MMIS) and to provide a wide scope of administrative, technical, clinical and analytical services to support the administration of the Departments health care programs. In 2004, the Department administered a competitive procurement for the next Fiscal Agent contract. Information about the procurement and the scope of the fiscal agent contract can be found on the Department website at dhfs.wisconsin.gov/rfp/.

That procurement requires the design, development and implementation (DDI) of a new MMIS over a period of 24 months. The DDI process began in January 2005 and implementation of the new MMIS is scheduled to occur early in 2007. The contract has a five (5) year base operational term with five (5) optional one year extensions. The scope of the fiscal agent contract currently includes requirements for the full scope of PBM systems and activities.

The following services are provided under the current Medicaid Fiscal Agent Contract with EDS and their subcontractors (subcontractors include Provider Synergies for PDL and Supplemental Rebate negotiation and APS for DUR, Recipient Lock-In and clinical consultation on cost containment initiatives).

Operate, maintain and enhance the federally required Medicaid Management Information System (MMIS). The MMIS and fiscal agent staff supports the following:

- Inbound claims logistics (paper and EDI receipt and registration)
- Claims adjudication (processing, review, approval, denial, suspension)

- Outbound claims logistics; provider payment and recovery, remittance advice
- Eligibility File and interface with CARES,SSA and Medicare for eligible recipients/participants of Medicaid/BadgerCare/ SeniorCare/FamilyCare
- Provider File of certified providers and managed care plans
- Managed Care enrollment processing and capitation calculation and payment
- HMO Encounter Data processing and reporting
- State and Federal reporting
- Prior Authorization Processing (registration, review, approval, suspension for Department review)
- Surveillance and Utilization Review including Drug Utilization Review
- Coordination of Benefits with health insurance and Medicare
- Estate Recovery Processing
- Drug Rebate Processing
- Pharmacy Point of Sale system and real time claims adjudication
- Recipient Identification Card Issuance
- Eligibility Verification
- Financial processing and reporting including premium collection for BadgerCare/Medicaid Purchase Plan
- Data Warehouse and Decision Support Services including for Medicaid claims analysis and DUR programs.
- Wisconsin Immunization Registry
- Written and Telephone Customer Service for Providers and Recipients/Participants
- Medical Consultants for review of Prior Authorizations and consultation on policy/program development
- Publications and Communications development and publishing
- Managed care contract monitoring and customer service
- SeniorCare application processing
- Actuarial services
- Analytical, technical and clinical staff to support ad-hoc reporting and analysis of data from the data warehouse requested by DHFS.

1.17 Wisconsin Medicaid Pharmacy Benefits – Fee-for-Service

Wisconsin Medicaid pays the lesser of: 1) the average wholesale price (AWP) minus 13% plus a dispensing fee, 2) the Wisconsin maximum allowable cost (MAC) plus a dispensing fee, or 3) the federal upper limit (FUL) plus a dispensing fee. The current dispensing fee is $4.38.

SeniorCare reimbursement levels are the same, except that SeniorCare provides a 5% enhancement on ingredient reimbursement.

Wisconsin provides fee-for-service prescription drug benefits in Medicaid and SeniorCare. Together, the dollar value of all prescriptions processed for payment under these programs exceeded $800 million in SFY 05. Beginning

January 1, 2006, Medicare Part D reduced drug expenditures in Medicaid by 64%. The most recent Medicaid FFS pharmacy quarterly report is attached as an appendix to this RFP. This report provides details on program trends as well as gross cost and utilization by drug and class.

In September 2000 Wisconsin implemented SeniorCare, a pharmacy only benefit program authorized through a federal Pharmacy Plus 1115 waiver (the waiver provides federal Medicaid match dollars for individuals up to 200 percent FPL; the State entirely funds benefits for people 200-240 percent FPL). More than 96,000 people had a prescription processed for payment by SeniorCare in state fiscal year 2005.

1.18 Current Wisconsin Medicaid FFS Pharmacy Management Policies

DHFS currently employs a number of prescription drug management strategies. Together, these have been successful in keeping Wisconsin's Medicaid prescription drug cost growth rate below national averages. The strategies employed include:

- **Maximum Allowable Cost (MAC)** – DHFS establishes MAC prices as the allowable reimbursement rate for most generic drug products. Generic products comprise about 60 percent of all MA-fee-for-service prescriptions, and MAC prices have been established for about 75 percent of generic products. Typically, Wisconsin MAC prices are lower than those established by most states and the federal government. Wisconsin MAC prices are available at the Medicaid website: http://dhfs.wisconsin.gov/medicaid4/pharmacy/data_tables/pdfs/legend_mac.pdf.

- **Brand Medically Necessary** – When generic products are available and on the MAC list, brand utilization of the same drug compound requires Prior Authorization. Less than 1 percent of prescriptions contain this over-ride, indicating that Wisconsin is experiencing success minimizing the use of brand-name drugs when generics are available. The Wisconsin Medicaid generic fill rate was 62% in December 2005.

- **Preferred Drug List** – The 2003-05 State biennial budget provided the Department new authority to establish a preferred drug list (PDL) and supplemental rebate program, Ch. 49.45 (49m), Wis. Stats. This provision authorizes the Department to design and implement a prescription drug cost control program that includes "a list of…preferred choices within therapeutic classes." The provision also establishes authorization for supplemental rebate agreements. In 2004 DHFS began working with Provider Synergies LLC to implement a PDL. To date, more than 50 classes have been included in the PDL. Supplemental rebates of approximately $36 million All Funds annually have resulted from these classes to date. Overall, the State is recouping 28%

of its gross drug expenditures through the combination of federal and supplemental rebates. Savings will continue to grow as additional market shift is achieved. Wisconsin joined a multi-state PDL in 2005. The Medicaid PDL is available at the Medicaid website: http://dhfs.wisconsin.gov/Medicaid/pharmacy/pdl/pd_list.pdf.

- **STAT PA** – The Wisconsin STAT-PA system is a Prior Authorization (PA) system that allows Medicaid-certified pharmacy providers to request and receive PA electronically, rather than on paper, for certain drugs. Providers are allowed to submit up to five PA requests per connection for touchtone telephone and help desk queries. More information about the pharmacy STAT PA system is available at the Medicaid website or at the vendor conference.

- **Diagnosis Restrictions** – Requires the pharmacist to submit a diagnosis for claims related to select drug classes. The claim is denied if the diagnosis is not approved as corresponding to the drug. This restriction applies to about 1 percent of reimbursed prescriptions. More information about current diagnosis restricted drugs is available at the Medicaid website: http://dhfs.wisconsin.gov/medicaid4/pharmacy/data_tables/diagnosis_restricted.asp.

- **Prospective Drug Utilization Review (Prospective DUR)** – This program provides an alert to the pharmacist regarding a patient's drug therapy at the point-of-sale (POS) before a prescription is filled. The report compares the new claim to patient's recent claim history and alerts the pharmacist to potential therapeutic duplication, drug-disease contraindications, drug-drug interactions, incorrect drug dosage or clinical abuse/misuse at the point of sale.

- **Retrospective Drug Utilization Review (Retrospective DUR)** – The Retrospective DUR identifies prescribing and utilization patterns that appear to fall outside best practice guidelines. Physicians are alerted by letter of potential drug therapy problems among their patients, such as therapeutic duplication, drug-disease contraindications, incorrect drug dosage or duration, drug-induced illness or clinical abuse/misuse among their patients.

  Wisconsin Retrospective DUR has also recently implemented a new quality improvement program. The Wisconsin Behavioral Pharmacy Feedback Program (BPFP) is designed to improve clinical care, while also holding down some of the projected increase in pharmacy costs. BPFP has partnered with Comprehensive NeuroScience, Inc. (CNS), to use available pharmacy claims data from Medicaid fee-for-service patients to compare the prescribing patterns of certain mental health drugs by individual prescribers with national guidelines. This is a time-limited program with

an initial contract expiration set for early 2007. Additional information about the BPFP is available in Attachment E.

- **Maximum Days Supply** – Limits reimbursement to no more than a thirty-four 34) days supply with exceptions for some (the list of which is in the process of expansion) maintenance drugs, per HFS 107.10, Wisconsin Administrative Code, http://www.legis.state.wi.us/rsb/code/hfs/hfs107.pdf.

- **Cost Containment Actions of the Governor's Pharmacy Commission** – In April 2006 this group recommended moving forward with tablet splitting and dose consolidation programs to further reduce pharmacy costs. The Commission also recommended providing incentive fee payments to pharmacists who are successful switching an existing brand prescription to a generic. The final Commission Report can be accessed online at http://dhfs.wisconsin.gov/medicaid4/pharmacy/prc/pdfs/prcfinal_041306.pdf

- **Pharmaceutical Care (PC)** – Wisconsin Medicaid provides pharmacists with an enhanced dispensing fee for PC services given to fee-for-service recipients. These services include enhanced education and counseling intended to increase patient compliance and prevent abuse or inappropriate use. The purpose of PC is to maximize the effectiveness of medications for the patient through intervention by the pharmacist. The Governor's Pharmacy Commission recently recommended action to simplify the Pharmaceutical Care fee structure to encourage program utilization. More information about PC is available at the Medicaid website: http://dhfs.wisconsin.gov/medicaid2/handbooks/pharmacy/dur/appendix9.htm. Additional information on the Department's practices in each of these areas can be obtained at the vendor conference and on the web at the indicated URLs.

SECTION 2

CONTRACT MONITORING

2.0 Overview

Section 2 of this RFP provides Respondents with the terms and conditions of contract monitoring imposed by the State during the implementation and ongoing project management of PBM services.

Please note that **no part of this section requires a response as part of the technical or cost proposals** that serve as the necessary components of bid submissions. This section is offered for Respondent information only and provides a preview of the type of monitoring requirements the Contractor will be subject to after the contract has begun.

2.1 Organizational Oversight

Providing the PBM Services called for in this RFP will require the coordination of work efforts on the parts of the Contractor, the State, and the State's MMIS Provider. The creative and/or adaptive work activities in design, development, implementation, and operation of the System envisioned in this RFP will hereinafter be referred to as the PBM Project, or simply the "Project." See Section 2.3.for requirements on managing the Project.

Contractors will report on their organizational structure, including the employment of significant actual or proposed subcontractors. Respondents must also include in the Proposal an Organizational Chart for the Project, defining how the Respondent intends to staff and manage the Project as well as the Project's relationship to the organization as a whole. The Proposal will delineate the organization and composition of the Project Management Team as well as describe the ways in which the Project Management Team will ensure coordination and communication both internally and among all subcontractors.

Upon award of a Contract, the Contractor, at the State's request, must additionally provide reasonable assistance in establishing and maintaining Communication Liaisons and effective coordination with internal and external stakeholder groups, governmental and community organizations and committees, and any entities demonstrating a legitimate interest in the performance or objectives of the Contract.

2.2 Proposed Key Personnel

The Contractor must provide a Project Team to be headed by an overall PBM Project Manager, whose responsibility is to carry out the tasks described in this RFP. The Project Manager must meet the following requirements:

- Three (3) years of project management experience.

- A record of successful supervision within the last five (5) years of the implementation and/or operation of a PBM or comparable service of similar size and complexity as that defined in this RFP.

The résumé of the proposed Project Manager must be included in the Proposal. The Project Manager must begin work on the Project on the effective date of the Contract and continue until the State verifies in writing that the PBM has been successfully implemented and is functioning seamlessly with MMIS.

Following successful implementation, the Contractor must designate an PBM Contract Manager. This Manager may, at the Contractor's discretion, be a different person from that chosen as the Project Manager. The Contract Manager must maintain regular and frequent contact with the State's PBM Contract Administrator (hereinafter referred to as the PBM Contract Administrator), designated State staff members, as well as appropriate staff of the State's MMIS Provider. His or her appointment and continuing assignment are subject to State approval. The State retains the right to require a replacement of personnel in this position for any legitimate performance reason. The replacement will be subject to State approval. Other key Contractor personnel may also be subject to the same review and approval protocol of the State.

The Contractor must assign the appropriate number and composition of project staff at all times during the Project to ensure the successful implementation and operation of the System. Furthermore, the Contractor must provide a plan whereby the Project Manager or designee must be available on-site at the State's facilities and/or at those of the State's MMIS Provider within twenty-four (24) hours of the State's request at no cost to the State. The State also expects the Project Manager or designee to be present at such facilities on a regular basis for scheduled status/update meetings. The final Project Plan must determine, as closely as possible, the actual amount of time the Project Manager or designee will be needed at State or MMIS Provider facilities.

2.2.1 Personnel Changes

The following protocol will apply to personnel changes in the Contractor's staffing complement:

- The State reserves the right to accept or reject the Contractor's personnel assignments. That right, however, must not be unreasonably or unlawfully invoked.

- The Contractor must not divert key personnel for any period of time, except in accordance with the procedures identified in this section. The Contractor must provide a notice of proposed diversion or replacement to the PBM Contract Administrator at least thirty (30) business days in advance together with the name(s) and qualifications of the person(s) who will take the place of the diverted or replaced staff. At least twenty (20) business days before the proposed diversion or replacement, the PBM Contract Administrator must notify the Contractor whether the proposed diversion or replacement is approved or rejected, and if rejected, must provide the reason(s) for such rejection.

- "Divert" or "diversion" is defined as the transfer of personnel by the Contractor to another assignment under the control of the Contractor and thus excludes the following: resignation, death, disablement, or dismissal for cause.

- Replacement staff must be on-site at least ten (10) business days prior to the departure date of the person being replaced. The Contractor must provide the State with reasonable access to any staff diverted by the Contractor.

- Replacement of key personnel who have terminated employment must be with persons of substantially equal or better ability and qualifications. The State must have the right to conduct individual interviews of proposed replacements for key personnel. The State must approve all proposed replacement personnel in writing before such personnel can be hired. The State reserves the right to reject any replacements of key personnel provided. That right, however, will not be unreasonably or unlawfully invoked.

- Any Contract staff reasonably determined by the State to be non-cooperative, inept, incompetent, or otherwise unacceptable must be removed by the Contractor after such problematic behavior has been documented by the State and the Contractor has been given a minimum of fifteen (15) business days to remedy the problems identified, but has failed to do so. In the event that an individual has been removed pursuant to a request from the State, the Contractor must have thirty (30) business days in which to fill the vacancy with another employee whose experience and skills, as indicated by the State's written consent, meet the approval of the State. Such approval by the State will not be unreasonably withheld or delayed.

2.3 Contractor's Responsibilities and Liabilities

The Contractor will be financially liable for the following:

2.3.1 Accounting and Audit Requirements

The following accounting and auditing standards and requirements must apply to the Contract issued as a result of this RFP:

2.3.1.1 Availability of Records

The books, records, documents, accounting practices, and facilities engaged in performing services under the Contract, or any subcontract relevant to the Contract (including Contracts with third party processors), must be subject to audit at any reasonable time and upon reasonable notice by the State, CMS, or their duly- appointed representatives.

2.3.1.2 Retention of Records

Financial records and reports pertaining to the Contract must be maintained for three (3) years following the end of the State Fiscal Year (June 30th) during which the Contract is terminated or State and Federal audits of the Contract have been completed, whichever is later. In the event of any audit, claim, negotiation, litigation or other action, records must be retained for the duration of the action.

2.3.1.3 Annual Financial Audit

The Contractor must make its annual financial audit report available to the State, either in hard copy or through internet access. The Contractor must respond to any inquiries related to the annual audit report from the State, CMS, or their duly appointed representatives. If, in the State's judgment, a serious financial condition is disclosed in the audit report, the State reserves the right to require the Contractor to submit a written corrective action plan to ensure continuity and safety of the System and its associated records. Failure to correct significant conditions may constitute grounds for Contract termination.

2.4 Contract Performance

Respondents must accept all provisions contained in the Contract Terms and Conditions, unless specific departures taken from particular terms and conditions

are noted in their proposals and approved by the State. Respondents must note all such departures in their proposals. Failure to note departures must constitute acceptance of all the terms and conditions. A proposal taking blanket exception to all or substantially all boilerplate contract provisions must be considered a non-compliant Proposal and must be rejected from further consideration for contract award. Respondents are encouraged to identify concerns with the contract terms during the period allowed for submission of questions..

2.4.1 Non-Compliance with Performance Standards or Contract Requirements

The State reserves the right to impose liquidated damages or corrective action provisions or to delay payment to the Contract, as described in the following sections. The remedies set forth do not preclude the use of any other remedy provided by the Contract or by applicable law.

The State reserves the right to find that the Contractor had reasonable cause for failure to meet a performance standard or Contract requirement. In such cases, the State must not hold the Contractor liable for the damages. The State's election not to invoke remedies in any instance of performance deficiency must not be deemed to be a waiver of the State's right to invoke remedies in any other instance.

2.4.1.1 Liquidated Damages

It is agreed between the Contractor and the State that the actual damages to the State as a result of the Contractor's failure to provide promised services would be difficult or impossible to determine with accuracy. The State and the Contractor therefore agree that liquidated damages must be a reasonable approximation of the damages that would be suffered by the State as a result thereof. Accordingly, in the event of such damages, at the written direction of the State, the Contractor must pay the State the indicated amount as liquidated damages. Amounts due the State as liquidated damages, if not paid by the Contractor within fifteen (15) business days of notification of assessment, may be deducted by the State from any funds payable to the Contractor pursuant to work performed under this Contract. The State must notify the Contractor in writing of any claim for liquidated damages pursuant to this paragraph on or before the date the State deducts such sums from funds payable to the Contractor. No delay by the State in assessing or collecting liquidated damages must be construed as a waiver of such rights.

The Contractor must not be liable for liquidated damages when, in the opinion of the State, incidents or delays result directly from causes beyond the control of and without fault or negligence of the Contractor. Such causes may include, but are not restricted to acts of God, fires, floods, epidemics, and labor unrest, but in every case, the delays must be beyond the control of and without fault or negligence of the Contractor.

2.4.1.2 Corrective Action Plan

The State must notify the Contractor in writing of the first incident of failure to meet one or more of the Performance Standards or Contract Requirements defined in Attachment D and request a Corrective Action Plan. The State must set a date for submission of this Plan. If the State does not receive the Plan by the due date and no extension has been requested or granted, the State may, at its discretion, invoke the appropriate "delayed payment" remedy per the schedule described in Section 2.5.1.3.

If the State receives the Plan by the due date, it must work with the Contractor to achieve a mutually agreed upon final Corrective Action Plan and schedule. The State may, at its discretion, invoke the appropriate "delayed payment" remedy if the Contractor does not meet the schedule and no extension has been requested or granted.

The State must notify the Contractor when it is satisfied that the problem has been corrected. If the State determines that, after the expiration of the Corrective Action Plan, the incident has occurred again (second incident), the State may, at its discretion, invoke the delayed payment schedule until such time as the condition is remedied, or assess liquidated damages as determined by the State.

2.4.1.3 Delayed Payments

The State may, at its discretion, delay payments to the Contractor according to the following schedule:

- First month: the State may delay payment of fifteen percent (15%) of total payment owed to the Contractor by the State.

- Second consecutive month: the State may delay payment of thirty percent (30%) of total payments owed to the Contractor by the State.

- Third and each additional consecutive month: the State may delay payment of forty-five percent (45%) of total payments owed to Contractor by the State.

  Payments may be delayed until the State is reasonably assured that the Contractor has fully complied with the performance standards or Contract requirements. Upon such assurance, the State must promptly pay the Contractor all outstanding payment amounts previously delayed.

SECTION 3

FORMAT FOR SUBMITTING TECHNICAL PROPOSAL

3.0 Overview

This section is intended to inform Respondents of the specific requirements necessary to complete the Technical Proposal portion of a procurement bid.

The state is accepting proposals for three different levels of PBM services as follows:

Procurement Package 1

Prospective DUR Rules, Algorithms, Profiling and Point-of-Sale Implementation
Preferred Drug List and Supplemental Rebate Solicitation/Negotiation
Prior Authorization
Claims Adjudication and Payment
Rebate Billing and Collection
Retrospective DUR
Cost Containment Consultation and Implementation
Interface with MMIS as necessary

Procurement Package 2

Prospective DUR Rules, Algorithms and Profiling
Preferred Drug List and Supplemental Rebate Solicitation/Negotiation
Prior Authorization
Retrospective DUR
Cost Containment Consultation and Implementation
Interface with MMIS as necessary

Procurement Package 3

Prospective DUR Rules, Algorithms and Profiling
Prior Authorization
Retrospective DUR
Cost Containment Consultation and Implementation
Interface with MMIS as necessary

Respondents may submit bids for any or all of these three procurement packages. Please note that if you choose to bid on more than one procurement package, you must submit a separate technical proposal for each one. Each separate technical proposal must be submitted as a stand-alone proposal that does not rely on cross-referencing information in any other proposal. This is so because each technical proposal will be scored independently.

The technical proposal must include the following:

1) A Statement of the Contractor's Qualifications and Experience as outlined in Section 3.1.

2) Responses to Technical Questions provided in Section 3.2.

3) Submission of a "Cost Savings Opportunity Report" based on a Medicaid/SeniorCare January-March 2006 pharmacy claims extract (accompanied by an April 2005-March 2006 medical claims extract) to be provided to Respondents who sign a data sharing agreement with the State of Wisconsin. The format for this report must follow specifications outlined in Section 3.3.

4) An Implementation and Integration Plan as specified in Section 3.4.

Each of these four components will be assigned a relative value for evaluation purposes to be determined by the State. The complete evaluation scoring system is subject to public review after the notice of intent to award contract.

3.1 Contractor's Qualifications and Experience

The technical proposal must include corporate background and experience. The response must detail the information in the sections below. Subcontractor's background and experience must be listed separately. If the Respondent is proposing the use of subcontractor(s), the Respondent must describe any existing or ongoing relationships, and list any projects on which the Respondent and subcontractor(s) have previously worked together.

A qualified Respondent must be a single, totally responsible prime contractor with any major subcontractors committed in writing to the intent of fulfilling specified roles.

3.1.1 Identification and Information

Provide the following information:

- Full organization, company, or corporate name;
- Address of organization's headquarters office;
- Type of ownership (proprietary, partnership, corporation);
- If a subsidiary or affiliate, identification of parent organization;
- The state in which the organization is incorporated or otherwise organized to do business;
- Federal taxpayer identification number;
- Name and title of person who will sign the contract;

- Name and title of company contact person who can answer questions regarding the organization's proposal;
- Contact telephone number;
- Contact facsimile number; and
- Contact e-mail address.

3.1.2 Corporate Qualifications

The proposal must include a description of the Respondent's corporate qualifications as it relates to the Respondent's experience in conducting projects similar in scope and complexity to that requested by this RFP, and consistent with the services and deliverable being proposed. This information must also be provided for all proposed subcontractors.

3.1.3 Corporate Experience

The proposal must include a description of the Respondent's particular experience in the areas listed below. This information must also be provided for all subcontractors the bidder proposes. The specific areas of experience are:

Procurement Package 1

Prospective DUR Rules, Algorithms, Profiling and Point-of-Sale Implementation
Preferred Drug List and Supplemental Rebate Solicitation/Negotiation
Prior Authorization
Claims Adjudication and Payment
Rebate Billing and Collection
Retrospective DUR
Cost Containment Consultation and Implementation
Interface with MMIS as necessary

Procurement Package 2

Prospective DUR Rules, Algorithms and Profiling
Preferred Drug List and Supplemental Rebate Solicitation/Negotiation
Prior Authorization
Retrospective DUR
Cost Containment Consultation and Implementation
Interface with MMIS as necessary

Procurement Package 3

Prospective DUR Rules, Algorithms and Profiling
Prior Authorization

Retrospective DUR
Cost Containment Consultation and Implementation
Interface with MMIS as necessary

The proposal must include a description and at least three (3) references from engagements or contract performed within the last five (5) years that demonstrate the Respondent's ability to perform the services proposed in response to this RFP. The information must include contract dates and customer points of contact, address, telephone number and e-mail, if available, from whom DHFS can obtain confirmation of Respondent performance. The Respondent must explain whether work was performed as a prime contractor or subcontractor. If the work was performed as a subcontractor, the Respondent must describe the scope of subcontracting activities.

3.2 Technical Questions

Complete technical proposals for each of the three procurement packages must include responses to questions as noted below:

Procurement Package 1 Requires Responses to Questions in these subsections:

3.2.1 Prospective DUR
3.2.2 Preferred Drug List and Supplemental Rebate Solicitation/Negotiation
3.2.3 Prior Authorization
3.2.4 Claims Adjudication and Payment
3.2.5 Drug Rebate Billing and Collection
3.2.6 Retrospective DUR
3.2.7 Cost Containment Consultation and Implementation

Procurement Package 2 Requires Responses to Questions in these subsections:

3.2.1 Prospective DUR
3.2.2 Preferred Drug List and Supplemental Rebate Solicitation/Negotiation
3.2.3 Prior Authorization
3.2.6 Retrospective DUR
3.2.7 Cost Containment Consultation and Implementation

Procurement Package 3 Requires Responses to Questions in these subsections:

3.2.1 Prospective DUR
3.2.3 Prior Authorization
3.2.6 Retrospective DUR
3.2.7 Cost Containment Consultation and Implementation

3.2.1 Prospective DUR

1. Describe your recommended clinical rules for Prospective DUR. How do you develop, implement and evaluate these rules?
2. Describe the technical methods you use to apply these rules, including the algorithms and profiles generated by this product.
3. Given the January-March 2006 pharmacy claims file DHFS has made available to you, establish a Prospective DUR plan for Wisconsin and itemize in detail the savings that will result from this (based on Q1/06 expenditures).
4. Describe how linkages to prescription claims history will be accomplished within the context of the specific "Procurement Package" for which you are completing this technical proposal.
5. Describe results you have achieved on other accounts in the area of Prospective DUR.

3.2.2 Preferred Drug List (PDL) and Supplemental Rebate Negotiation

1. Describe your process for providing meta-analysis of clinical evidence to state staff and the Prior Authorization (PA) committee.
2. Describe any multi-state or multi-payer pooling groups you manage and your plan for Wisconsin participation in this pool. How will this participation impact Wisconsin capacity for independence in PA decision making?
3. How do you assure complete transparency in negotiating supplemental rebates? Will you sign a state-supplied attestation indicating that your supplemental rebate arrangements include no hidden fees?
4. What modifications would you recommend to the Wisconsin PDL and what is the financial impact of these recommendations?
5. Sample generic fill rates: If you're working with states, please provide the most recent generic fill rate available for each state (program-wide as well as by the 55 drug classes currently on the Wisconsin PDL, see Appendix A). If you're working with private clients, provide the most recent generic fill rates (program wide and by Wisconsin PDL classes) available for ten such clients.
6. For the 55 drug classes currently on the Wisconsin PDL (see Appendix A), please provide the final **brand only** net ingredient cost per prescription (combined for all drugs in class) that you can achieve based on Wisconsin's Q1/06 mix and volume and contracts you have negotiated. In performing this calculation, you must assume no changes in preferred products from the Wisconsin PDL provided in Attachment A.

7. What other PDL/Supplemental Rebate related actions would you recommend to further reduce ingredient cost (from the amounts specified in your answer to question 6)?

3.2.3 Prior Authorization (PA)

1. How would you proposed to modify or enhance Wisconsin PA process and methods.
2. Discuss how your proposed PA methods minimize burdens on providers or disruptions in recipient care?
3. Describe your proposed use of technology to innovate or enhance the performance of the PA submittal and approval process.
4. Give five examples of rule-based PA from simple to complex.
5. Discuss whether your proposed PA solution requires a call center to support PA adjudication? Please provide specifics regarding when, why and how.
6. Please indicate how your proposed solution plans for conversion of existing PAs.
7. Discuss your proposed solution, if any, for auto-adjudication of grandfathering PAs?
8. Describe your process for tracking and reporting PA transactions in a way that enables pro-active management and adjustments to the PA process as needed to improve program performance.

3.2.4 Claims Adjudication and Payment

1. Describe how the implementation of your Point-of-Sale (POS) system would provide for recipient continuity of care given the current status of an existing Wisconsin POS system. Be specific about the need for transition and how such a transition could be successfully managed according to strict timelines.
2. How will you ensure that claims will be processed with the accurate prescriber ID?
3. Describe how your system processes claims reversals and claim adjustments.
4. What are the normal hours of availability for your proposed online adjudication system? Describe your procedures for POS system downtime, including regularly scheduled maintenance, power failure and other unexpected items.
5. Describe your documented disaster recovery support for critical production platforms and applications.
6. Describe how your system will maintain or interface with the MMIS to obtain client eligibility information.

7. Describe how your benefit verification will interface with current recipient eligibility cards (Wisconsin Forward and SeniorCare).
8. Describe how your POS system can provide access of claims adjudication data to recipient and provider service call centers that will be operated by the MMIS vendor.

3.2.5 Drug Rebate Billing and Collection

1. Describe your experience managing drug rebate invoicing, agreement and dispute resolution program.
2. Describe your process for providing rebate reporting.
3. Provide examples of any products you offer that assist state customers in assessing post-rebate net cost and utilization patterns.
4. What proactive measures does your rebate management program undertake to reduce the incidence of rebate disputes?

3.2.6 Retrospective Drug Utilization Review

1. Describe how you propose to modify and/or enhance Wisconsin DUR process and methods.
2. Describe the staff resources you would offer to assist the DUR Board.
3. Describe your proposed use of data technology to innovate or enhance the performance of the DUR process and ultimately to affect prescriber behavior.
4. Give five examples of rule-based DUR from simple to complex.
5. Describe your process for DUR tracking and reporting in a way that enables pro-active management and adjustments to the claims adjudication and payment process as needed to improve program performance.

3.2.7 Cost Containment Consultation and Implementation

1. What cost containment strategies not otherwise identified among the requirements of section 3 do you plan to include in your PBM proposal? Please provide a detailed description of these strategies and examples of how you have employed them in other settings.
2. Are you willing to guarantee a final net prescription drug benefit “per member per month” cost under this contract that includes penalties for not maintaining this guarantee? If so, please provide this rate and provide background on how you’ve derived it.
3. Please specifically address how e-prescribing fits into your plan.

3.3 Cost Savings Opportunity Report

Section 3.3 is a required component of the technical proposal that provides Respondent's with the opportunity to complete an analysis of an actual Wisconsin Medicaid and SeniorCare pharmacy claims extract from Quarter 1 of calendar year 2006. This data set also includes one year's worth of medical claims (April 2005-March 2006) to enable analysis that matches pharmacy utilization against diagnostic criteria. The data set has been prepared in compliance with HIPAA standards, and respondents will be required to sign a data sharing agreement as well. To request a copy of the DVD containing the data extract, please contact Rich Albertoni, DHCF Budget and Policy Analyst, at alberrs@dhfs.state.wi.us.

Using the extract, Respondent's are required to assemble a Cost Savings Opportunity Report that accomplishes the following:

1. Provides a management level summary of Quarter 1 2006 Cost and Utilization, stratified by Medicaid and SeniorCare.
2. Identifies Prospective DUR interventions based on specific claims activity and provides documentation of how intervention savings have been calculated.
3. Identifies Prior Authorization interventions based on specific claims activity and provides documentation of how intervention savings have been calculated.
4. Identifies Retrospective DUR interventions based on specific claims activity and provides documentation of how intervention savings have been calculated.
5. Identifies Other Cost Containment interventions based on specific claims activity and provides documentation of how intervention savings have been calculated. Note that **Other Cost Containment interventions cannot be based on policy variables that will not be within the control of the PBM, - specifically reimbursement or dispensing fee rate setting or establishment of recipient cost sharing levels.** Evaluators will not grant credit to any such interventions. Evaluators will also not grant credit to overly-general interventions such as "increase use of generic drugs by 2%" for which no plan of achievement is offered.

Evaluators will score the Cost Savings Opportunity Report based on the extent to which proposed interventions represent innovations from current efforts. Evaluation staff will independently estimate projected savings of proposed interventions using the same set of estimate criteria for all Respondents.

Because the data extract represents gross spend, rebate strategies will not be counted as a successful strategy in this report.

The report achieving the highest evaluation score will be the report representing innovations that will result in the greatest verifiable (note that as part of the evaluation process, Respondents whose savings estimate are deemed not verifiable will be notified and provided a reasonable opportunity to respond to verification needs within the timeline of the award process) cost savings to the State. The plan must be achieved within the bounds of the Procurement Package for which you are applying.

3.4 Implementation and Integration Plan

Responses to the following questions are required:

1. Based on the applicable procurement package, please provide your assessment of MMIS integration requirements and how you propose to achieve those requirements.

2. Describe your action plan for a standard program implementation. For purposes of this evaluation, assume an implementation timeframe of 120 days. The action plan should describe each key action step, the organization responsible, and start/stop dates. Please indicate specific functions that would be the responsibility of the State.

3. The Contractor may be required to preload a two-year pharmacy claims history file, including claims and prior authorization. Describe your experience and capabilities in this regard.

SECTION 4

FORMAT FOR SUBMITTING COST PROPOSAL

4.0 Instructions for Submitting Cost Proposal

The cost proposal should be submitted along with the sealed technical proposal, in a separate, sealed envelope. The proposal will be scored using a standard quantitative calculation where the maximum points will be awarded to the proposal with the lowest cost with higher cost proposals receiving a percentage of the cost maximum. Various costing methodologies and models are available to analyze the cost information submitted to determine the lowest costs to the State. The State will select one method and use it consistently throughout its analysis.

Completeness and clarity of cost is essential for the Department in determining the best value for the State of Wisconsin. **Respondents cost proposals must consist of the following four items:**

- A total procurement package price, inclusive of all costs, for the initial 5-year contract period.
- Reimbursable Cost Rates
- Change Order Cost Rates
- Statement of Approach to Risk-Based Fees

In Section 1.0.2 of this document, State considerations regarding carve-out of the PBM services from the MMIS contract were outlined. It was noted in that section that, should the State decide to procure for any of the three packages defined in this RFP, the services contained in that package will be removed from the current MMIS contract.

Therefore, for purposes of assembling cost proposals for this RFP, Respondent's must assume that funding from the contract award that will result from this RFP will be the only source of State funding supporting these PBM activities at the time the contract from this RFP takes effect.

Cost proposals should not include reimbursements to pharmacies. Costs included must only reflect payments the State will make to the contractor for implementation and operation of pharmacy benefit management services as detailed in Section 4.1. Cost proposals should be based on the volume of Calendar Year 2006, quarter 1 pharmacy claims and pharmacy recipients that are included in the data extract provided via DVD to Respondents (see Section 3.3 for requirements of receiving this DVD).

The cost proposal will account for 25% of the evaluation score. Total RFP evaluation will consider the relationship between costs reflected in the cost proposal and cost savings opportunities provided in the technical proposal. This allows for the possibility that a higher cost PBM approach that yields more benefit savings could receive a higher total score than a low cost approach that yields less savings.

4.1 Cost Proposal Requirements

The cost proposal shall be on letterhead stationary or on the Cost Proposal Form located in the Attachments Section of this RFP. It must be signed by a Respondent's representative authorized by the Respondent to give a rate proposal for a contract. The cost proposal must be submitted in a separate envelope from the technical proposal. Cost proposals must include the following four items:

4.1.1 Total Procurement Package Price

The total procurement package price must be submitted for the entire 5-year initial contract period. It should include implementation costs as well as base operational costs, defined as follows:

Implementation Costs – Total costs associated with design, development, testing and implementation.

Base Operational Cost – Fixed operating costs associated with daily ongoing operations after implementation.

The total procurement package price must be itemized by the primary functions included in the package for which the Respondent is submitting a bid. For each of these functions, provide the proposed total implementation cost and annual base operation costs. However, it is required that in providing this itemization, Respondents do not limit pricing only to these functions. In other words, the total and annual prices must be inclusive of all costs you anticipate, even if they do not fit one of the noted functions.

4.1.2 Reimbursable Costs

The reimbursable costs are expenses reimbursed directly to the contractor for specific operating expenses which are not included in the base operations costs. These costs may not be incremented by corporate allocation or markup. Reimbursable costs include postage/mailing costs and other miscellaneous costs. The State requires the contractor to use due diligence to obtain the most cost effective pricing for these costs. Respondents must include in their cost proposal cost rates for all anticipated reimbursable expenses.

4.1.3 Change Order Costs

Change order costs are expenses paid to the contractor for design, development and implementation and operation of changes to the scope of the initial procurement. Respondents must include in their cost proposal a specified hourly rate for change order expenses.

4.1.4 Statement of Approach to Risk-Based Fees

Respondents are required to submit a statement indicating their willingness to provide risk-based performance guarantees. The State is interested in such guarantees and scoring of cost proposals will, in part, be based on the extent to which Respondents provide them.

4.2 Fixed Price Period

All prices, costs, and conditions outlined in the proposal shall remain fixed and valid for acceptance for a minimum of twenty-four (24) months after commencement of the contract.

4.3 Inflationary Adjustment

The contractor may receive an inflationary adjustment to his/her base fee inclusive of all costs, twenty-four months after commencement of the contract and annually thereafter. This increase may be based on either seventy-five percent (75%) of the increase in the prevailing Consumer Price Index for Urban Wage Earners (CPI-U) for Milwaukee, Wisconsin, in effect for the quarter ending January of the current year, or five percent (5%) of the current contractor's base fee, whichever is lower.

SECTION 5

CONTRACT BUSINESS REQUIREMENTS

5.0 Sample PBM Business Requirements

This section provides a detailed itemization of *current* PBM business requirements for Wisconsin Medicaid and SeniorCare. These items are provided for the purpose of giving Respondents a sense of the breadth and scope of business requirements they should assess themselves as capable of meeting before submitting bids for this procurement. **Do not reply to these items in constructing your technical proposal. Technical proposals must be formatted according to the requirements of Section 3.**

It should also be noted that these detailed requirements provide a point-in-time view of Wisconsin Medicaid/SeniorCare PBM business requirements that are subject to change. A revised set of detailed business requirements will be incorporated as performance benchmarks in the final terms and conditions of the contract negotiated with the Contractor that emerges with the successful bid. Also, it should be noted that not all of the business requirements detailed below apply to each of the three procurement packages and may not be included in the final requirements based on the package ultimately selected for procurement.

Terms and conditions of the contract will also be consistent with the State administrative rules governing Medicaid and SeniorCare. These rules are contained in the specific administrative rule chapters HFS 107 and 109. The contents of these chapters can be found at adminrules.wisconsin.gov

5.1 Prospective DUR

5.1.1 The contractor's POS system will include the capacity for applying clinical rules for real-time Prospective drug utilization reviews (Prospective DUR) in accordance with policies and guidelines recommended by the DUR Board. This review requires real-time match between DUR rules and recipient pharmacy and medical claims. Review of medical claims will require interface with the MMIS medical claims processing system operated by the MMIS vendor.

5.1.2 The Prospective DUR function will require implementation of an online audit trail of all alerts, including all data submitted by the provider and all responses sent to the provider. The contractor shall utilize a drug updating service for clinical information necessary to perform DUR alerts.

5.1.3 Prospective DUR edits may include, but not be limited to, the following data matches:

- drug to drug interaction
- drug to disease contraindication
- pregnancy
- therapeutic duplication
- early and late refills
- drug to age
- additive toxicity
- other available modules for drug utilization review
- high dose
- insufficient quantity
- sub-optimal regimen

5.1.4 Prospective DUR system requirements also include the capacity to send online, real-time alerts to providers and to allow the prescriber to override Prospective DUR alerts for a specific prescription, or to reverse the claim submitted. The contractor must establish and maintain medical, drug, and pregnancy profiles for Prospective DUR processing that will require interface with the MMIS medical claims system.

5.1.5 The contractor shall also:

5.1.5.1 Assure state compliance with Federal Omnibus Budget Reconciliation Act (OBRA) 1990 mandated Prospective DUR requirements.

5.1.5.2 Provide dispensing and prescribing providers with Prospective DUR training and technical assistance, as specified by the State.

5.1.5.3 Provide information and data, as required, to the State and the Wisconsin DUR Board to support Prospective DUR criteria.

5.1.5.4 The processing requirements for Prospective DUR include identification and monitoring drug usage for FFS claims including but not limited to, over utilization, under utilization, therapeutic duplication, drug/disease contraindication, drug/drug interaction, incorrect drug dosage, incorrect duration of drug treatment. The contractor shall establish and maintain Prospective DUR therapeutic criteria tables for therapeutic exception criteria standards that can be used to identify specific pharmaceutical use problems. The criteria tables must have quantitative significance values or severity ratings that may appear on patient-specific alert reports that must be approved by the State.

5.1.6 Generate the following Prospective DUR reports including but not limited to:

5.1.6.1 Summarization report of the severity and the number of alerts that have occurred over a given period. Based upon the results of this report, specific reports to display additional detail for any given type or category of alert may be requested by the State. Listings of all drug claims and diagnostic information per member and the amount of money involved

5.1.6.2 User-defined period of time (e.g., all DUR activity that occurred for a date range)

5.1.6.3 Alerts/denials by types, quantity, and by prescribing provider and pharmaceutical provider.

5.1.6.4 Generate reports based upon selected pharmacy and physician criteria, such as 1) identifying NDC numbers, generic drug codes, or therapeutic classification codes of drugs and specific diagnosis codes, and 2) NDC numbers, generic drug codes, or therapeutic classification codes and quantities of drugs prescribed by a specific physician or filled by a specific pharmacy.

5.2 Preferred Drug List and Supplemental Rebate Agreements

5.2.1 The contractor shall design, implement and maintain a preferred drug list aimed at high cost therapeutic classes or new product introductions to be identified by the vendor.

The contractor shall also serve as the Department's agent in negotiating supplemental rebates with pharmaceutical manufacturers. It is critical that all negotiated supplemental rebates involve complete transparency that assures 100% remittance of all rebates to the State.

The PDL should be designed to promote preferences for the use of generic and lower cost brand products that are considered to be clinically comparable and as medically effective as higher cost options in the same drug class. An effective PDL will achieve market shift toward generic and lower cost brand products. The program design must include the following:

A stringent clinical review of medical and scientific data shall be undertaken to evaluate classes of drugs and determine those drugs that provide equivalent clinical outcomes. The evaluation shall include careful consideration of the impact of establishing preferred products on the health and safety of the Wisconsin Medicaid population. Recommendations shall be made for preferred drugs based on a thorough review of clinical effectiveness, safety and health outcomes, followed by

an analysis of relative costs of the alternative drugs in each class under consideration. Drugs shown to provide similar effectiveness, which are less costly, would be identified as preferred drugs. The Wisconsin Medicaid Program and PA Advisory Committee must review all recommendations, with final approval provided by the DHFS Secretary. It will be critical that the vendor be capable of integrating the PDL function with Wisconsin Medicaid's existing PA program.

The vendor's responsibilities related to the PDL function will be as follows:

5.2.2 PDL Design and Implementation

5.2.2.1 Using pharmaco-economic modeling, develop recommendations for selected classes of drugs that would yield the highest overall effectiveness as preferred drug categories and provide determinations as to recipient access and health outcomes. In making these recommendations, also consider and incorporate the latest available findings of the Oregon Evidence-Based Research Consortium (of which Wisconsin is a member).

5.2.2.2 Identify the specific criteria for identification of drug products as preferred drugs, within the class, based on clinical and cost-effectiveness standards.

5.2.2.3 Prepare and present recommendations based on clinical and/or pharmaco-economic studies to the DHFS and the Wisconsin Medicaid PA Advisory Committee. The vendor must provide evidence that the inclusion of the selected drugs or classes of drugs in the PDL would not negatively impact the Medicaid population. In addition, evidence must be provided that the more costly drugs have no significant clinically meaningful therapeutic advantage in terms of safety, therapeutic efficacy, or clinical outcome compared to those "preferred" or less-costly drugs used to treat the same condition.

5.2.2.4 Develop and submit to DHFS a schedule for review, approval and implementation of drug classes to the PDL.

5.2.2.5 In the cost proposal, prepare a methodology and provide a detailed calculation of estimated savings to be incurred through implementation of the PDL. Estimated savings should be based on analysis of Wisconsin Medicaid data and reflect market shift at the National Drug Code (NDC) level.

5.2.3 PDL Ongoing Operations

5.2.3.1 Develop and, following approval by DHFS, mail or make available in electronic (e.g., web-based) format, necessary

correspondence to providers, recipients, Medicaid service agencies, advocacy groups and other interested parties regarding PDL guidelines, policies and procedures.

5.2.3.2 Twice a year, review and evaluate utilization data (including that available through DHFS) for performance under existing drug classes, and areas of improvement for both clinical impact and cost effectiveness of PDL classes.

5.2.3.3 Review and evaluate new drugs and drug classes for potential inclusion/exclusion on the PDL (prior to Medicaid coverage where feasible).

5.2.3.4 Design and implement targeted educational efforts, including web-based efforts, to improve compliance among outlier prescribers and pharmacies in order to maximize the effectiveness of the PDL. Monitor and report on outcomes of these educational efforts.

5.2.4 PDL Reporting

Prepare the following cost savings reports monthly:

5.2.4.1 Utilization shift reports by NDC, drug class and manufacturer.

5.2.4.2 Cost Savings resulting from changes in prescribing, by drug and drug class.

5.2.4.3 Generate a report indicating compliance with PDL drug classes by prescribers.

5.2.4.4 Expenditure per claim comparison (monthly/quarterly/yearly).

5.2.4.5 Quarterly evaluation of the effectiveness of the PDL, including recommendations for changes to PDL drugs, the criteria for review and approval of drugs, results in shifting market share toward generics detailing opportunities for additional savings.

5.2.4.6 Report on total estimated savings, and projected future savings from the PDL, on a monthly basis for the initial twelve (12) months of operation, and quarterly thereafter.

5.2.4.7 Quarterly reports demonstrating the nature and extent of educational interventions to outlier prescribers, and the outcomes of those interventions.

The vendor's responsibilities related to supplemental rebates appear in the following section:

5.2.5 Supplemental Rebate Negotiations

5.2.5.1 In association with the development of the PDL, provide an opportunity for all effected manufacturers to provide supplemental rebates to the State.

5.2.5.2 Serve as DHFS' agent to negotiate supplemental rebates for Medicaid and other State pharmacy programs, with pharmaceutical manufacturers in relation to preferred drugs. The resulting contract regarding supplemental rebates shall be between the manufacturer and the State.

5.2.5.3 Consistent with State guidelines, provide annual opportunities for manufacturers to amend rebate agreements. Also provide opportunities for a manufacturer to amend its rebate agreement when a new product receives FDA approval or at DHFS direction if significant market conditions warrant review. Report to DHFS and the Medicaid PA Advisory Committee on an ongoing basis, the results of those negotiations and their impact on the PDL. DHFS shall have final approval on all rebate agreements.

5.2.5.4 Provide ongoing rebate analysis and suggestions for enhancing rebates and/or lowering net pharmacy costs.

5.2.5.5 Review and analyze utilization data for performance under existing drug classes and areas for improvement for both clinical impact and cost effectiveness of PDL classes.

5.2.5.6 Using utilization data provided by DHFS and its Medicaid fiscal agent, provide projections of quarterly savings attributable to supplemental rebates and market shifts.

5.3 Prior Authorization

5.3.1 Accept and respond to PA requests/amendments by paper, fax, telephone, Internet or electronic transmission. Accept and respond to Internet and electronic transmission using National Council for Prescription Drug Programs (NCPDP) standard for retail pharmacy. Accept real-time entry of PA requests/amendments through an automated voice response (AVR) system.

5.3.2 Accept online, real-time entry and update of PA requests, including initial entry of PA requests pending determination. Scan PA documents and attachments and make them available for online retrieval. Implements and maintain an automated process to link hard copy PA attachments received in the mail, with the corresponding PAs that have been submitted electronically. Implement and maintain an automated workflow system

for routing, reviewing, adjudicating, tracking, and updating of PA requests/amendments.

5.3.3 Generate and distribute State approved PA request forms and attachments to providers. Provide the State with online access to PA request/ amendment data. Generate and distribute right to appeal notices to recipients when a PA is denied or modified. Identify and re view PA requests for which an appeal has been submitted, indicate the outcome of such reviews, and identify PAs for which an appeal has been filed. Update PA records based on claims processing to indicate that the authorized service has been used or partially used, including units and/or dollars, during each PA request period.

5.3.4 Generate and mail written PA adjudication notices to providers within one (1) business day of decision.

5.3.5 Adjudicate PA requests with ninety-nine percent (99%) accuracy. Generate and mail notice of appeal rights letter to recipients with one (1) business day of decision. Finalize ninety -five percent (95%) of PA requests/amendments within ten (10) business days and one hundred percent (100%) of PA requests/amendments within twenty (20) business days from receipt of all required information.

5.3.6 Ensure that the average time for automated response to each provider "send" transaction is four (4) seconds or less and providers do not encounter a busy signal ninety nine percent (99%) of the time.

5.4 Claims Adjudication and Payment

5.4.1 The POS adjudication system must generate online, real-time electronic response to the provider immediately after transmission of a claim. The response must address whether the claim submitted is acceptable and services are covered. The POS adjudication system must also have the capacity to notify the provider online of any applicable error codes. This system will require implementation of an online audit trail of all POS transactions, including all data submitted by the provider and all responses sent to the provider. Other specific technical requirements of the POS claims adjudication system shall include, but not be limited to, the following:

5.4.2 Accept multiple National Drug Codes (NDCs) on a POS claim to support compound drug pricing.

5.4.3 Accept online, real-time claims reversal/adjustment for ninety (90) calendar days from date of adjudication in POS.

5.4.4 Process paper adjustments to real-time and paper claims for 365 calendar days from date of service.

5.4.5 Apply different dispensing fees to drug claims based on State-defined criteria.

5.4.6 Compare actual acquisition cost and usual and customary charge information to billed charges on drug claims.

5.4.7 Send online, real-time POS Prospective DUR alerts and denials.

5.4.8 Allow the submitting provider to override POS Prospective DUR alerts for a specific prescription, or to reverse the claim submitted.

5.4.9 Edit to ensure that claims submitted for recipients assigned to a specific provider under the Recipient Lock-In Program are either billed by the assigned provider.

5.4.9.1 Edit for NDC codes included in recipient lock-in categories.

5.4.9.2 Provide cost avoidance edits for drugs and notify the provider through an online, real-time response when another payer is primary, in addition to information about the other payer.

5.4.9.3 Perform all necessary logic and consistency editing to screen claims before acceptance including, but not limited to logical dates of service (e.g., valid dates, not future dates), number of services performed consistent with a span of time, insurance coverage, prescription limitations (e.g., days supply, number of fills).

5.4.9.4 Edit all required data elements for presence and validity on all entered claims, according to state approved design specifications.

5.4.9.5 Edit all claims against provider, recipient, reference and other data.

5.4.9.6 Perform editing of pharmacy claims to identify non-covered drugs based on a table of State-approved Generic Code Numbers (GCN), and/or NDCs, or NDC ranges not covered by Wisconsin Medicaid; notify the provider through an online, real-time response when a drug is not covered.

5.4.9.7 Provide edits for drugs requiring prior authorization, and allow providers to immediately apply for prior authorization, submit information required to justify prior authorization, receive authorization if appropriate, and resubmit a claim for adjudication online.

5.4.9.8 Provide edits for drugs requiring specific diagnosis codes.

5.4.9.9 Edit claims for a valid prescriber number.

5.4.9.10 Support managed care editing for inclusion or exclusion of pharmacy services.

5.4.9.11 Define, update, and apply changes to policy and procedural edits as directed by the state.

5.4.9.12 Price pharmacy claims consistent with Wisconsin reimbursement rules in accordance to state policy including, but not limited to, the ingredient Maximum Allowable Cost (MAC), Estimated Acquisition Cost (EAC), Average Wholesale Price (AWP), appropriate dispensing fees, pharmaceutical care, compound drugs.

5.4.9.13 Allow the submittal of decimal units and calculate payment based on the decimal versus rounding to a whole unit in POS.

5.4.9.14 Use State approved standards to identify exceptional drug utilization patterns.

5.4.9.15 Generate all State-defined and State-approved reports regarding claims. Report types must include periodic reports required by CMS, expenditure reports, recipient and provider profiles, reports summarizing statistics on real-time transactions, reports of unsuccessful transmissions and claim errors or rejections, audit trail reports of all real-time transactions and management reports.

5.4.9.16 The Contractor must administer a Coordination of Benefits (COB) program during the claims adjudication process. The Contractor's POS system must deny payment for all claims where the recipient is covered by one or more primary carriers until the provider indicates that claim has been full adjudicated (paid or denied) by the other payer(s). The Contractor must successfully utilize the State's Third Party Liability (TPL) data or the eligibility records to ensure that all payment opportunities are exhausted.

5.4.9.17 The Contractor must process COB claims for the claim balance remaining after Medicare payment, as reflected on submitted forms.

5.4.9.18 The Contractor must message providers with information for all TPL carriers provided on individual eligibility records (e.g., carrier code, policy number, policy holder, effective dates of coverage, etc.) during claims adjudication, for both commercial and other public sector coverage, to efficiently administer the COB program.

5.4.9.19 Utilize a drug updating service for pricing and related information necessary to process claims according to State defined policies and procedures.

5.5 Drug Rebate Billing and Collection

5.5.1 Invoicing

5.5.1.1 Develop format and content of invoice cover letters for manufacturers. Develop written procedures for new and ongoing invoicing tasks. Respond to inquiries from manufacturers, CMS and State staff regarding drug invoicing. Verify invoice accuracy prior to generating invoices to manufacturers. Contact manufacturer to advise of discrepancies in invoices and develop correction plan. Update manufacturer information. Produce and mail invoices quarterly to manufacturers for rebates and rebate adjustments. Implement positive controls for rebate receivables. Receive and process rebate payments from manufacturers. Maintain and post drug rebate receipts and over payments to the accounts receivable system. Produce quarterly drug invoice utilization data for CMS. Request the issuance of refund checks to manufacturers in the event of overpayment. Process prior period unit rebate amount adjustments. Compute drug rebate interest charges.

5.5.1.2 Provide the State with online access to drug rebate data. Develop, maintain, and update an automated drug rebate invoicing system for federal and state funded drug rebate programs in compliance with all federal and state reporting requirements to ensure accurate drug rebate invoices are produced for manufacturers. Identify and track drug rebate information by program.

5.5.1.3 Receive and process quarterly CMS unit rebate amount (URA) data drug rebate tape containing pricing information for producing invoices. Receive and process other rebate related information from CMS, the State or manufacturers.

5.5.1.4 Exclude specific classes of drugs from the rebate process based on State and Federal regulations. Maintain and update multiple manufacturer enrollment dates, termination dates and address changes from CMS, the State or from manufacturers. Identify covered entities participating in the 340B drug discount pricing program downloaded from CMS file web site, identifying providers excluded from invoicing as required under the Veterans Health Care Act of 1993, and the State funded SeniorCare Program.

5.5.1.5 Generate and submit quarterly drug rebate invoices, in State and Federal approved format, invoice cover letters and mailing labels to manufacturers for current quarter as well as prior quarters. Scan current and future drug rebate correspondence in an electronic format that can be easily and quickly accessed.

5.5.1.6 Provide online access to drug rebate invoicing data and reports. Track status of collections, non-payments, non-responders and all invoicing activities. Develop and generate outlier reports that include identification of potential errors including but not limited to decimal quantity errors and unit of measure errors. Reports are used to resolve unit discrepancies and avoid disputes prior to invoicing.

5.5.1.7 Produce and send quarterly State drug invoice utilization data to CMS. Develop, generate and submit to the manufacturers invoice non-responding and collection letters in accordance with all federal and State reporting requirements.

5.5.1.8 Maintain complete and accurate records of all checks received, units adjustments, write-offs, resolutions, interest paid, original and corrected units, outstanding balances and contacts with manufacturers on current and prior drug rebate/invoice information in compliance with all federal and State reporting requirements. Maintain confidentiality of labeler and State information in accordance with all Federal and State confidentiality statutes, regulations and requirements.

5.5.1.9 Automatically calculate drug rebate interest charges in compliance with all Federal and State reporting requirements. Invoice and accept invoice information transmitted directly from the manufacturers using several mediums including but not limited to electronic, diskette, paper, email or Internet.

5.5.1.10 Transmit, through multiple mediums, requested invoice and detailed drug utilization claim information to CMS, the State and manufacturers. Maintain audit trail of transactions related to the drug rebate invoices and provide the capability to display original and all revised invoice records. Update corrections to invoice data as necessary. Validate units of measure from CMS quarterly data tape to MMIS drug file for consistency and reporting on exceptions. Credit and reconcile Drug Rebate collections, based on NDC, to the individual claim record in compliance with State and Federal reporting requirements.

5.5.1.11 Process CMS URA data, produce, and submit invoices to manufacturers within fifteen (15) days of receipt of the tape or within sixty (60) days after the end of each quarter. Report

utilization data to CMS within ninety (90) calendar days after the end of a quarter.

5.5.2 Rebate Dispute Resolution

5.5.2.1 Develop written procedures for new and ongoing dispute resolution tasks. Perform drug rebate dispute research, tracking and resolution activities in compliance with Federal and State dispute resolution reporting practices and timeline requirements.

5.5.2.2 Develop format and content for letter templates. Provide drug rebate staff to respond to drug rebate inquiries from CMS, manufacturers, billing pharmacies and State staff. There are currently approximately 900 labelers participating in Wisconsin programs. Respond to requests for information from manufacturers.

5.5.2.3 Provide the state with online access to the dispute resolution data. Develop, maintain, and update an automated drug rebate system with dispute resolution data for multiple drug rebate programs in compliance with all Federal and State requirements. Track and maintain a history of dispute related information from CMS, the state, pharmacies, and manufacturers including but not limited to dispute resolution data and reports, status of disputes, collections/overpayment and non-payments.

5.5.2.4 Develop and generate drug rebate dispute/resolution letters in compliance with all Federal and State requirements. Provide online, updateable letter templates for dispute resolution collection letters and follow-up collection letters. Develop, generate, and submit letters and reports to pharmacies for prescription verification of disputed units by manufacturers.

5.5.2.5 Automatically recoup payments for unverified prescriptions if billing pharmacy does not respond within State defined timeframe requirements. Track and maintain records of all checks received, unit adjustments, write-offs, resolutions, interest paid, original and corrected units, outstanding balances and contacts with manufacturers on current and prior quarter drug rebate dispute resolution data.

5.5.2.6 Update and report adjustment corrections from manufacturers and pharmacy billing errors to dispute resolution and claims data to facilitate future processing. Automatically calculate rebate amounts, adjustments overdue, and interest charges due. Identify rebate amounts and interest by program, by manufacturer, by NDC and by rebate quarter for late, disputed or unpaid rebates.

5.5.2.7 Develop, maintain, and update accounts receivable information regarding transactions for increases/decreases, multi-payer checks, interest, prior quarter adjustments, rebate per unit/pricing changes and payments/credits. Develop, update, and maintain audit trail for the dispute resolution process changes and provide the capability to display original and corrected records made to the data.

5.5.2.8 Generate and maintain invoice details and post payment details consistent with Reconciliation of State Invoice (ROSI) and Prior Quarter Adjustment Summary (PQAS). Provide online query capability to the State for researching prescription claim information.

5.6 Retrospective Drug Utilization Review *(Levels 1 and 2)*

5.6.1 Conduct regular program evaluation. Facilitate quarterly evaluations of focused retrospective DUR criteria and interventions. The DUR Board should review these evaluations and any recommended changes to the DUR criteria should be referred to the State for approval. These evaluations should use research models including control/comparison groups or repeated time series to assess the effectiveness of current retrospective DUR practices.

5.6.2 Ensure compliance with Federal OBRA 90 and OBRA 93 requirements related to retrospective DUR, and educational interventions. Generate educational materials for prescribers, dispensers and recipients to support identified interventions, produced four (4) to twelve (12) times a year. Review literature and findings on retrospective DUR and report to the DUR Board and the State on a regular basis.

5.6.3 Present draft standards and criteria to the DUR board for review and make any modifications recommended by the Board, as approved by the State. Submit board meeting materials to the State for approval prior to distribution. Facilitate DUR board meetings, produce meeting materials including printing/distributing meeting agendas, reserving a meeting location, and recording/distributing meeting minutes.

5.6.4 Provide a pharmacy consultant to manage and direct the retrospective DUR for the State and act as representatives to the DUR board.

5.6.5 The processing requirements for retrospective DUR include identification and monitoring drug usage for FFS claims including but not limited to over utilization, under utilization, therapeutic duplication, drug/disease contraindication, drug/drug interaction, incorrect drug dosage and incorrect duration of drug treatment. Operate a web-based retrospective DUR system.

5.6.6 Establish and maintain retrospective DUR therapeutic criteria tables with quantitative significance values or severity ratings for therapeutic exception criteria standards that can be used to identify specific pharmaceutical use problems. Collect and apply retrospective DUR data to criteria tables on a monthly basis.

5.6.7 Complete the CMS annual Drug Utilization Review (DUR) report as described in Section 1927 (g)(3)(D) of the Social Security Act. Provide an automated ongoing periodic review (no less frequently than quarterly) of claims data and other records in order to identify patterns of fraud, abuse, overuse, or inappropriate or medically unnecessary care among physicians, pharmacists, and recipients, or claims associated with specific drugs or groups of drugs. This review must involve pattern analysis, using predetermined standards, of physician prescribing practices, drug use by individual patients and, where appropriate, dispensing practices of pharmacies. This program must be provided either through Medicaid Management Information System (MMIS) or an electronic drug claims processing system that is integrated with MMIS. If the contractor provides DUR-specific software that is proprietary, the contractor must provide the State with a minimum of three (3) licenses.

5.6.8 Identify for follow up recipients and providers who have been found to exhibit verified drug use or prescribing aberrations. Measure and track specific drugs, providers, dispensers, and groups of providers and clients. Retrospective DUR should also develop client profiles as well as provider profiles per State specifications.

5.6.8.1 Profile and identify providers (prescribers and dispensers) for possible face-to-face intervention and/or provider education using criteria recommended by the DUR Board and approved by the State. This activity should identify and support issues for intervention through non-punitive visits with prescribers and/or dispensers such as face-to-face interventions, provider education, audit and potential referral to Wisconsin Department of Regulation and Licensing (DRL).

5.6.9 Generate the following retrospective DUR reports including but not limited to:

5.6.9.1 Measure and track specific drugs, providers, groups of providers and clients, and develop client profiles and provider profiles

5.6.9.2 Monthly summary reports containing a count of recipients whose profiles are being flagged for the current month, a listing of recipient names and ID numbers, and a listing of all drugs that caused profiles to be generated. These reports will contain a count of the providers that caused profiles to be flagged and a listing of their names and identify what criteria were used

5.6.9.3 Specific patient drug history reports which include a chronological listing of all drugs being taken and summarize the number of prescribers/providers involved in a patient's therapy.

5.6.9.4 Drug therapy risk assessment report. This report should be generated before and after interventions are instituted to determine the impact of the DUR program on drug expenditures and drug therapy induced hospitalizations. This report must be available at the first DUR Committee meeting following report generation.

5.6.9.5 Quarterly follow-up drug history profiles and reports.

5.6.9.6 Educational intervention recommendations and reports based on retrospective DUR analysis, including a mix of educational interventions.

5.6.9.7 Comparison of retrospective DUR program findings for month-to-date and year-to-date.

5.6.9.8 Costs and savings of the retrospective DUR processing program monthly, quarterly, or annually.

5.6.9.9 Listing all retrospective DUR alerts encountered for specified members within the last twelve (12) months.

5.6.9.10 Generate the claim, provider, recipient file and control reports for the State or outside DUR contractor when requested.

5.6.10 Perform automated Retrospective DUR activities including, but not limited to:

5.6.10.1 Review of existing retrospective criteria and submittal of new criteria based on evidenced based, peer review research.

5.6.10.2 Identification of target populations. Typical populations include individuals with diabetes, asthma, HIV/AIDS, heart disease, Hepatitis C, and mental illness.

5.6.10.3 Establishment of evidence-based practice guidelines, including collaborative practice models with physician and support-service providers.

5.6.10.4 Patient self-management education including primary prevention, behavior modification programs, and compliance and surveillance.

5.6.10.5 Periodic reporting including feedback, which may include communication with patient, physician, health plan and ancillary providers, and practice profiling.

5.6.10.6 Review of nursing home drug utilization including analysis of utilization by nursing home, by class of drug and/or provider.

5.6.10.7 Generate quarterly retrospective DUR summary reports that include aggregate information about retrospective DUR activities to the State and DUR board.

5.6.11 Update retrospective DUR files as recommended by the Wisconsin DUR Board within ten (10) business days of the State's approval. Provide quarterly retrospective DUR summary reports to the State and DUR board within ten (10) business days of the end of the quarter. Provide the CMS DUR annual report to the State by June 1st every year.

5.7 Cost Containment Consultation and Implementation

5.7.1 Recipient Lock-In: he contractor will administer the recipient lock-in program in accordance with State policies and procedures. Operational requirements of this intervention include the following:

5.7.1.1 Notify providers and recipients of their selection as a preferred/assigned lock-in provider and inform them of their responsibilities. Receive and maintain documentation from providers for evaluating recipients for the lock-in program. Maintain evidence showing reasons for lock-in. Provide a pharmacist and other appropriate health care professionals, approved by the State, to represent the State at administrative hearings.

5.7.1.2 Provide staff with lock-in program knowledge to meet regularly, and on an ad hoc basis, with the State to discuss the lock-in program. Enter recipient lock-in data and provider information for use in claims processing. Conduct reviews to identify the appropriate timeframes to send lock-in related correspondence.

5.7.1.3 Enter recipient lock-in data and activities in the automated tracking system. Implement and maintain an electronic record of recipient restriction and limitations data, including restricted service types/codes, assigned provider, and effective dates to support the claims processing functions. Apply special claims adjudication policies to claims submitted by providers who are not the recipient's designated provider and who have no referral.

5.7.1.4 Develop and maintain automated algorithms, based on criteria provided by the State, designed to identify recipients to be placed in the lock-in program. Test lock-in algorithms for expected outcomes prior to use in production system. Identify the specific area where a recipient has over-utilized services and send recipient-specific data electronically to the State. Electronically

receive approved lock-in recommendations, profiles, and other related information from the State.

5.7.1.5 Generate the following lock-in related letters to recipients and providers including, but not limited to:

- Notification to recipient of lock-in status
- Second letter requesting recipient to designate medical provider (MP)
- Notification to recipient of MP designation
- Notification of appeal status
- Notification to providers listing assigned lock-in recipients

5.7.1.6 Implement and maintain an automated tracking system to accommodate lock-in data and activities including, but not limited to lock-in provider number, lock-in provider name, lock-in effective dates.

5.7.1.7 Track recipient lock-in activities, including but not limited to, claims, appeals, assigned provider referrals and process status such as initial identification, recommendation for the program and re-evaluation; enter, update, store, display, change and delete lock-in data, including but not limited to Provider type, Provider ID, initial date of restriction, lock-in begin dates and end dates.

5.7.1.8 Maintain a physician referral form (electronic and paper versions). Generate online lock-in activity reports as specified by the State, including, but not limited to the number of profiles created, the number of individuals locked in and released, cost savings and general program evaluation.

5.7.1.9 Provide online inquiry access to lock-in data for State approved users. Prepare a monthly report that lists all recipients with a lock-in on file for the month, and new lock-in recipients, applying all changes to reflect updates made during the month as directed by the State.

5.7.2 Other Cost Containment Consulting and Implementation: Under the terms of the contract, vendors will be required to contribute their expert clinical, economic and benefit management perspectives to support DHFS policy development in continuing to mitigate the rising costs of medications via product preferences and enhanced rebates. The State is seeking consultant services for comprehensive policy and technical analysis regarding these policy concerns, based on state-of-the-art practices in public and non-public pharmacy management settings. The analyses will be used to shape additional Wisconsin Medicaid program strategies.

5.7.2.1 Use data provided by DHFS and its Medicaid fiscal agent to analyze existing claims utilization data and subsequently consult with DHFS staff regarding prospects for additional market shift strategies.

5.7.2.2 Provide consultation regarding national trends among private insurers and state pharmacy assistance programs related to preferred drugs and drug class products.

5.7.2.3 Develop specific strategy recommendations for Wisconsin Medicaid, including product specific rebate strategies/methodologies and preferred drug management techniques and recommendations.

5.7.2.4 Assist DHFS with retrospective analyses of the cost and utilization impact of adopted preferred drug list items and supplemental rebate agreements.

5.7.2.5 Provide educational material/communications to prescribers, recipients, and other interested parties within two (2) months of DHFS implementation of PDL changes.

5.7.2.6 Provide other consulting services as identified and needed to assist DHFS with preferred drug and supplemental rebate policy development and program management.

5.7.2.7 Provide consultation and implementation oversight for specific cost containment strategies such as pill splitting and dose consolidation activities.

5.8 General Requirements

5.8.1 Meet PBM general requirements related to ongoing operational staff, state access to online systems, security, implementation of maintenance projects (budget changes), ongoing provider training and publications, customer service, provider payments and EOB's, document scans, availability and retention, financial reporting, privacy notices, HIPAA compliance, NCPDP participation, file transfers, post pay auditing and other items to be identified in final contract terms.

Appendix A

Web Address to
Wisconsin Preferred Drug List

To access this PDL, please copy and paste the following web address into your Internet navigator address bar:

http://dhfs.wisconsin.gov/Medicaid/pharmacy/pdl/index.htm